Mental Health Commission of Canada

Commission de la santé mentale du Canada

Opening Minds in High School: Results of a Contact-based Anti-stigma Intervention – Partnership Program Calgary

Michelle Koller, Shu-Ping Chen, Fiona Haynes and Heather Stuart

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1 OPENING MINDS: CHANGING HOW WE SEE MENTAL ILLNESS

Stigma is a significant concern for those living with a mental illness. Stigma is a primary vehicle for the entrenchment of discriminatory behaviours, and has been identified as a major barrier to timely and accessible care, recovery, and quality of life for persons living with mental illnesses. As such, reducing the stigma and discrimination associated with mental illness is becoming an increasingly important focus. One particular area of focus is that of the healthcare sector.

As part of its 10-year mandate, The Mental Health Commission of Canada (MHCC) has embarked on an anti-stigma initiative called Opening Minds (OM) to change the attitudes and behaviours of Canadians towards people with a mental illness. OM is the largest systematic effort undertaken in Canadian history to reduce the stigma and discrimination associated with mental illness. OM is taking a targeted approach, with healthcare providers being one of its main target groups. OM's philosophy is not to reinvent the wheel, but rather to build on the strengths of existing programs from across the county. As such, OM is conducting evaluations of various programs to determine their success at reducing stigma. OM's goal is to replicate effective programs nationally.

For more information, go to: www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx

2 INTRODUCTION AND PURPOSE

Stigma and discrimination have gained the attention of the public health and policy communities as a hidden and costly burden cause by society's prejudicial reaction to people with a mental illness (World Health Organization, 2001). Stigma and discrimination pose major obstacles in virtually every life domain, carrying significant negative social and psychological impacts. Reducing stigma and discrimination have become important policy objectives at both international and national levels (Sartorius & Schulze, 2005). The 2009 launch of the Mental Health Commission's Opening Minds anti-stigma/anti-discrimination initiative marked the largest systematic effort to combat mental illness-related stigma in Canadian History.

The Opening Minds program has partnered with a number of programs that deliver contact-based education to primary and high school students throughout Canada. Contact-based education involves people who have experienced a mental illness to educate students by telling their personal stories and allowing time for active discussion. In some cases, teacher lesson plans accompany the classroom presentations.

This report is intended to provide programs with an overview of their key evaluation results.

3 PROGRAM DESCRIPTION

The Partnership Education Program celebrates its 20th anniversary in 2014. Since 1994, the program has offered contact-based education on schizophrenia and related disorders through giving facts and information along with the perspective of personal stories of mental illness and recovery. Since its inception, the program has spoken to over 200,000 people across Alberta, and is a proactive partner with medical and public service professionals, educational bodies and community agencies.

The Partnership Education Program was developed to address the stigma and lack of understanding around schizophrenia, a serious and chronic mental illness affecting 1 in 100 individuals worldwide. Schizophrenia has historically been seen as a devastating diagnosis from which there is 'no return,' and is commonly linked to an idea of people who are out of control, hopeless, untreatable and even dangerous. There is often concern if not outright fear of the diagnosis which causes individuals who live with schizophrenia or psychosis to become isolated and self-stigmatized, in turn seriously impeding recovery. The program seeks to clarify myths and stereotypes and bring understanding and compassion through the medium of simple human interaction. The power of contact-based education has been shown through numerous studies, and the Partnership Education Program has experienced that power for the past 20 years. The inherent goal is that it is not possible to maintain a negative stereotype of an individual with mental illness when the person in front of you is warm, eloquent, well-prepared, intelligent and engaging. To show people in recovery with aspirations and achievements helps the community to throw out the idea of schizophrenia as a 'garbage can' diagnosis and instead to develop respect and a deeper understanding of the human experience and a sense of hope.

A Partnership presentation combines a team approach with an arresting level of honesty and hope, through the sharing of lived experience. Presentations are carefully planned to express both the pain of the disorder and the hope of recovery, allowing audience members to participate in the emotional journey

of the speakers. It is critically important that the stories are balanced and end positively in order that the audience members experience empathy by seeing the presenters as courageous and inspirational. One of the unique features of the program is the family member perspective. It is the case that family members are deeply impacted by a loved one's illness, and in many cases become the primary support for that person, yet their experience is rarely heard. Through the Partnership program, audiences have come to understand that mental illness is not a one-person problem, but an issue that affects us all. Family members find renewed optimism in hearing the stories of other presenters, and are able to use the telling of their own stories to find perspective and healing.

The healing aspect of talking through one's experience is a powerful benefit that continues to effect change over the longer term. The format of the Partnership Education program allows for ongoing development of individual's presented material. Over time, individuals both remember more and feel able to talk about additional experiences as they become more confident in taking the risk of speaking publicly. There is often emotion in describing events for the first time; repeated telling does not cause dull acceptance but creates a true integration of that experience for the individual, lessening the pain in a therapeutic way. Participants regularly report an increase in confidence and self-esteem as a direct result of working as presenters, and also report having a sense of meaningfulness added to their lives in their ability to teach others through the program.

Finding opportunities for employment and community involvement is still a major challenge for individuals with serious mental illness and one of the key goals of the Partnership program was to offer employability training and meaningful work in a supportive environment. The Schizophrenia Society of Alberta was an early pioneer in the provision of paid employment for individuals with serious mental illness and has been an active part of the movement towards encouraging employers to look at those individuals as a viable and talented workforce. Part of the work done with program participants is to help them recognize the skills they have developed and how those might be applicable to other situations in life including the pursuance of further education or mainstream employment. We fully encourage individuals to build a resume and have goals for transition into other employment if that is right for them, and to continue to build on their skills and challenge themselves wherever they are on their recovery path.

An unanticipated fringe benefit of the Partnership Education Program is the support presenters have been able to offer audience members looking for help for themselves or a loved one. Because of the honesty and approachability of presenters, audience members feel able to talk with them after the presentations and receive information on where to obtain help or find resources.

The Partnership Education program continues to grow and develop, responding to the changes in learning styles and the new information about schizophrenia and psychosis coming from reputable studies. The presenting team and staff across the province are actively involved in the ongoing progression of the program to keep it relevant and engaging for all audiences. We are moving forward with using video clips, animation and music as well as face-to-face interaction to help young people access the material in a way that works for them. We actively recruit younger presenters to create that sense of connection with younger audiences which is having a beneficial impact. A new project with W P Puppets will be launched in the near future that will involve a unique mobile art installation as a teaching aid for younger youth and parents about the lived experience of mental illness and where to find resources. The Partnership

Education program is a vibrant, living program that continues to challenge the stigma of mental illness, one classroom at a time.

4 APPROACH TO DATA COLLECTION

Students were surveyed before and after the contact-based intervention.

All programs participating in this network initiative used the same pre- and post-test survey questionnaires to collect their data. These surveys were adapted from items used by the six contact-based programs that participated in the instrument development phase of this project. The resulting Stigma Evaluation Survey contained 22 self-report items. Of these:

- 11 items measured **stereotyped attributions**
  - controllability of illness – 4 items,
  - potential for recovery – 2 items, and
  - potential for violence and unpredictability – 5 items
- 11 items measured expressions of **social tolerance**, which include both social distance and social responsibility items
  - desire for social distance – 7 items, and
  - social responsibility for mental health issues – 4 items

All items were scored on a 5-point agreement scale, ranging from strongly agree to strongly disagree. To avoid potential response sets, some items were positively worded while others were negatively worded. Items were scored so that higher scores on any item would reflect higher levels of stigma. The scales had good reliability in this pooled sample with a pre-test Cronbach's alpha of 0.85 for the Stereotype Scale and 0.83 for the Social Tolerance Scale. Both are well above the conventional threshold of 0.70 indicating that they are highly reliable. Information on gender, age, grade, and prior contact with someone with a mental illness (close friend or family member) was also collected.

Seventy-nine pre-tests and 50 post-test surveys were collected (a total of 125 surveys) but of these, only 44 were able to be matched for analysis. Given the large number of unmatched surveys and the potential for introducing bias by leaving out data from subjects that could not be matched, results presented here are unmatched. This means that the chances of finding statistically significant differences will be reduced. Absolute percentage differences that are in excess of 10% will be used to highlight differences that are potentially noteworthy, even if they do not reach statistical significance.

5 RESULTS

5.1 Sample Characteristics

Seventy-nine students completed the pre-test survey and 50 completed the post-test. The characteristics of the pre- and post-test groups are presented in Table 1. Sample characteristics a similar between the pre- and post-test groups. A greater proportion of males participated. The majority of students were 15 years old and were in grade 10.

Table 1. Sample Characteristics

Characteristic	Pre-test % (N=79)	Post-test % (N=50)
Gender		
• Male	56.3% (40)	57.8% (26)
• Female	43.7% (31)	42.2% (19)
• Missing	-- (8)	-- (5)
Age		
• 14	5.1% (4)	6.0% (3)
• 15	66.7.% (52)	72.0% (36)
• 16	17.9% (14)	16.0% (8)
• 17	10.3% (8)	6.0% (3)
• Missing	-- (1)	-- (0)
Grade		
• 10	74.4% (58)	78.0% (39)
• 11	16.7% (13)	16.0% (8)
• 12	9.0% (7)	6.0% (3)
• Missing	--(1)	-- (0)
Contact – Does someone you know have a mental illness (multiple responses accepted)		
• No	9.2% (7)	25.0% (12)
• Uncertain	21.1% (16)	14.6% (7)
• Close friend	18.4% (14)	29.2% (14)
• Family member	21.1% (16)	22.9% (11)
• Somebody else	17.1% (13)	14.6% (7)
• I do	27.6% (21)	12.5% (6)
• Missing	-- (2)	-- (2)

5.2 Stereotyped Attributions

Stereotyped attributions items are shown in **Tables 2, 3** and **4**. For ease of presentation, items were recoded into three groups: agree (strongly agree and agree), neutral, and disagree (disagree and strongly disagree). Table 2 shows the majority of respondents held positive (non-stereotypical) attitudes toward people with a mental illness on the controllability items. For example, before the intervention, students tended to disagree with the common stereotypes people with a mental illness could snap out of it if they wanted (84% disagree), get what they deserve (83% disagree), tend to bring it on themselves (76% disagree), or that people with mental illnesses often don't try hard enough to get better (76% disagree).

Also reported in **Table 2** is the change score from pre-test to post-test. Three of the Controllability items changed in the expected direction with the largest positive change being for the item "People with a mental illness tend to bring it on themselves." At baseline, 76% disagreed with this statement whereas 92% disagreed at post-test (a 16% positive change).

Table 2. Controllability Items

Stereotyped Attributions Items	Pre-test % (n=79)	Post-test % (n=50)	% Change
4. People with a mental illness tend to bring it on themselves.			
• Strongly disagree/disagree	75.6% (59)	92.0% (46)	16.4
• Unsure	12.8 % (10)	6.0% (3)	-6.8
• Strongly agree/ agree	11.5% (9)	2.0% (1)	-9.5
• Missing	(1)	(0)	
5. People with mental illnesses often don't try hard enough to get better.			
• Strongly disagree/disagree	75.6% (59)	80.0% (40)	4.4
• Unsure	17.9% (14)	12.0 % (6)	-5.9
• Strongly agree/ agree	6.4% (5)	8.0% (4)	1.6
• Missing	(1)	(0)	
6. People with a mental illness could snap out of it if they wanted to.			
• Strongly disagree/disagree	83.5% (66)	88.0% (44)	4.5
• Unsure	12.7% (10)	8.0% (4)	-4.7
• Strongly agree/ agree	3.8 % (3)	4.0% (2)	0.2
• Missing	(0)	(0)	
14. Most people with a mental illness get what they deserve.			
• Strongly disagree/disagree	83.3% (65)	83.7% (41)	0.4
• Unsure	11.5% (9)	10.2% (5)	-1.3
• Strongly agree/ agree	5.1% (4)	6.1% (3)	1.0
• Missing	(1)	(1)	

Table 3 shows the stereotyped attributions for the recovery items. Again, prior to the intervention, the majority of respondents held positive (non-stereotypical) attitudes toward people with a mental illness on both items. At post-test, both showed positive change with the greatest for the item "People with a mental illness need to be locked away" (a 10% positive change). There was a 9% positive change for the item "Most people with a mental illness are too disabled to work."

Table 3. Recovery Items

Stereotyped Attributions Items	Pre-test % (n=79)	Post-test % (n=50)	% Change
3. Most people with a mental illness are too disabled to work.			
• Strongly disagree/disagree	73.4% (58)	82.0% (41)	8.6
• Unsure	17.7 % (14)	10.0% (5)	-7.7
• Strongly agree/ agree	8.9% (7)	8.0 % (4)	-0.9
• Missing	(0)	(0)	
15. People with serious mental illnesses need to be locked away.			
• Strongly disagree/disagree	74.4% (58)	84.0% (42)	9.6
• Unsure	14.1% (11)	12.0% (6)	-2.1
• Strongly agree/ agree	11.5% (9)	4.0% (2)	-7.5
• Missing	(1)	(0)	

Table 4 shows the stereotyped attributions for violence and unpredictability. All five items changed in a positive direction. The largest change was for the item "People with a mental illness are often more dangerous than the average person." On the post-test, 82% of respondents disagreed with the statement, reflecting a 45% improvement; this was the largest positive change realized for any one item. The second highest positive shift was seen for the item "People with a mental illness often become violent if not treated," with a 42% positive shift.

Table 4. Violence/Unpredictability Items

Stereotyped Attributions Items	Pre-test % (n=79)	Post-test % (n=50)	% Change
7. People with a mental illness are often more dangerous than the average person.			
• Strongly disagree/disagree	36.7% (29)	82.0 % (41)	45.3
• Unsure	30.4% (24)	10.0% (5)	-20.4
• Strongly agree/ agree	32.9% (26)	8.0% (4)	-24.9
• Missing	(0)	(0)	
8. People with a mental illness often become violent if not treated.			
• Strongly disagree/disagree	24.1% (19)	66.0% (33)	41.9
• Unsure	41.8% (33)	24.0% (12)	-17.8
• Strongly agree/ agree	34.2% (27)	10.0% (5)	-24.2
• Missing	(0)	(0)	
10. Most violent crimes are committed by people with a mental illness.			
• Strongly disagree/disagree	59.5% (47)	92.0% (46)	32.5
• Unsure	30.4% (24)	4.0% (2)	-26.4
• Strongly agree/ agree	10.1% (8)	4.0% (2)	-6.1
• Missing	(0)	(0)	
11. You can't rely on someone with a mental illness.			
• Strongly disagree/disagree	70.9% (56)	74.0% (37)	3.1
• Unsure	17.7% (14)	22.0% (11)	4.3
• Strongly agree/ agree	11.4% (9)	4.0% (2)	-7.4
• Missing	(0)	(0)	
12. You can never know what someone with a mental illness is going to do.			
• Strongly disagree/disagree	21.8%(17)	38.8% (19)	17.0
• Unsure	23.1% (18)	26.5% (13)	3.4
• Strongly agree/ agree	55.1% (43)	34.7% (17)	-20.4
• Missing	(1)	(1)	

5.3 Expressions of Social Tolerance

Social tolerance items are shown in **Tables 5** and **6**. **Table 5** presents the items that relate to the expression of social distance. Prior to the intervention, the majority of students showed non-stigmatizing responses for all items but one, with positive responses ranging from 57% to 82%. Two fifths (40%) disagreed with the item that involved the most intimate social interaction prior to the intervention: "If I know someone had a mental illness I would not date them."

Most items shifted in a positive direction, showing increased tolerance at the post-test. The largest positive change was seen for the item "I would be upset if someone with a mental illness always sat next to me in class." At baseline, 70% disagreed with this item. At the post-test, this increased to 86% indicating a 16% positive shift.

Table 5. Social Distance Items

Social Distance items	Pre-test % (n=79)	Post-test % (n=50)	% Change
18. I would be upset if someone with a mental illness always sat next to me in class.			
• Strongly disagree/disagree	69.6% (55)	86.0% (43)	16.4
• Unsure	15.2% (12)	6.0% (3)	-9.2
• Strongly agree/ agree	15.2% (12)	8.0% (4)	-7.2
• Missing	(0)	(0)	
19. I would not be close friends with someone I knew had a mental illness.			
• Strongly disagree/disagree	78.5% (62)	76.0% (38)	-2.5
• Unsure	15.2% (12)	18.0% (9)	2.8
• Strongly agree/ agree	6.3% (5)	6.0% (3)	-0.3
• Missing	(6)	(0)	
20. (R) I would visit a classmate in hospital if they had a mental illness.			
• Strongly agree/ agree	64.1% (50)	68.0% (34)	3.9
• Unsure	24.4% (19)	22.0% (11)	-2.4
• Strongly disagree/disagree	11.5% (9)	10.0% (5)	-1.5
• Missing	(1)	(0)	
21. I would try to avoid someone with a mental illness.			
• Strongly disagree/disagree	75.9% (60)	82.0% (41)	6.1
• Unsure	13.9% (11)	14.0% (7)	0.1
• Strongly agree/ agree	10.1% (8)	4.0% (2)	-6.1
• Missing	(6)	(0)	
22. (R) I would not mind it if someone with a mental illness lived next door to me.			
• Strongly agree/ agree	82.1% (64)	90.0% (43)	7.9
• Unsure	14.1% (11)	6.0% (3)	-8.1
• Strongly disagree/disagree	3.8% (3)	4.0% (2)	0.2
• Missing	(1)	(0)	
24. If I knew someone had a mental illness I would not date them.			
• Strongly disagree/disagree	39.7% (31)	40.0% (20)	0.3
• Unsure	34.6% (27)	42.0% (21)	7.4
• Strongly agree/ agree	25.6% (20)	18.0% (9)	-7.6
• Missing	(1)	(0)	
25. I would not want to be taught by a teacher who had been treated for a mental illness.			
• Strongly disagree/disagree	59.5% (47)	74.0% (37)	14.5
• Unsure	22.8% (18)	18.0% (9)	-4.8
• Strongly agree/ agree	17.7% (14)	8.0% (4)	-9.7
• Missing	(0)	(0)	
Note: (R) Signifies the item was reverse coded in the scale calculation. Higher scale scores reflect higher levels of stigma.			

Social responsibility items are presented in **Table 6**. Before the intervention, students were generally socially responsible when a time commitment was not involved, such as telling a teacher a student was being bullied (89%) or sticking up for someone who had a mental illness if they were being teased (87%). The greatest improvement was seen for the item "I would tutor a classmate who got behind in their studies because of their mental illness," with a 9% positive shift.

Table 6. Social Responsibility Items

Social Responsibility items	Pre-test % (n=79)	Post-test % (n=50)	% Change
28. (R) I would tell a teacher if a student was being bullied because of their mental illness.			
• Strongly agree/ agree	88.6% (70)	88.0% (44)	-0.6
• Unsure	7.6% (6)	6.0% (3)	-1.6
• Strongly disagree/disagree	3.8% (3)	6.0% (3)	2.2
• Missing	(0)	(0)	
32. (R) I would stick up for someone who had a mental illness if they were being teased.			
• Strongly agree/ agree	87.3% (69)	92.0% (46)	4.7
• Unsure	10.1% (8)	4.0% (2)	-6.1
• Strongly disagree/disagree	2.5% (2)	4.0% (2)	1.5
• Missing	(0)	(0)	
33. (R) I would tutor a classmate who got behind in their studies because of their mental illness.			
• Strongly agree/ agree	49.4% (39)	58.0% (29)	8.6
• Unsure	36.7% (29)	22.0% (11)	-14.7
• Strongly disagree/disagree	13.9% (11)	20.0% (10)	6.1
• Missing	(0)	(0)	
34. (R) I would volunteer my time to work in a program for people with a mental illness.			
• Strongly agree/ agree	39.2% (31)	36.0% (18)	-3.2
• Unsure	35.4% (28)	44.0% (22)	8.6
• Strongly disagree/disagree	25.3% (79)	20.0% (10)	-5.3
• Missing	(0)	(0)	
Note: (R) Signifies the item was reverse coded in the scale calculation. Higher scale scores reflect higher levels of stigma.			

6 PROGRAM SUCCESS

In order to provide an overall measure of the success of the intervention, we chose an a priori cut-off score of 80% correct. Though somewhat arbitrary, we have used this cutoff in previous work to count the number of students who achieve an "A" grade or higher following an educational session. More specifically, success was measured by comparing the proportion of students who obtained 80% or more correct (non-stigmatizing) answers on the post-test compared to the pre-test.

Figure 1 shows the cumulative percent of the Stereotyped Attributions items reflecting non-stigmatizing responses. Prior to the intervention, 26% of students gave a non-stigmatizing response to at least 9 of the 11 questions (signifying an "A" grade). At post-test, this was 67% (reflecting a 41% improvement).

Figure 1. Cumulative Percent of Stereotype Scale Items Reflecting Non-stigmatizing Response

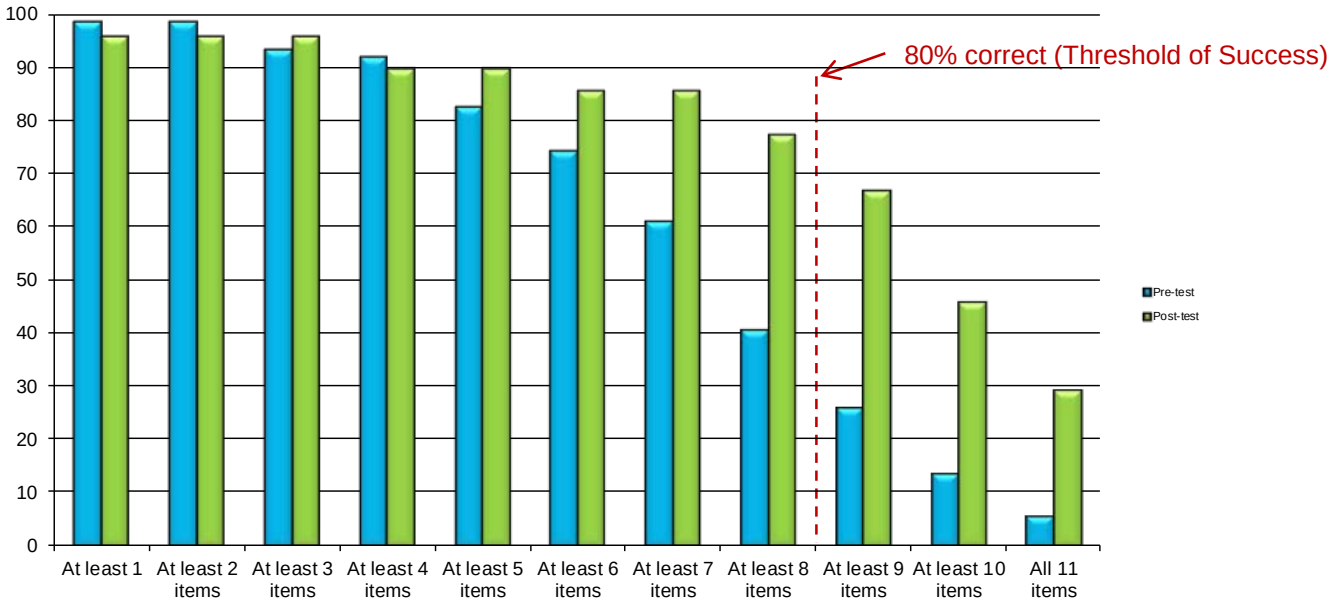
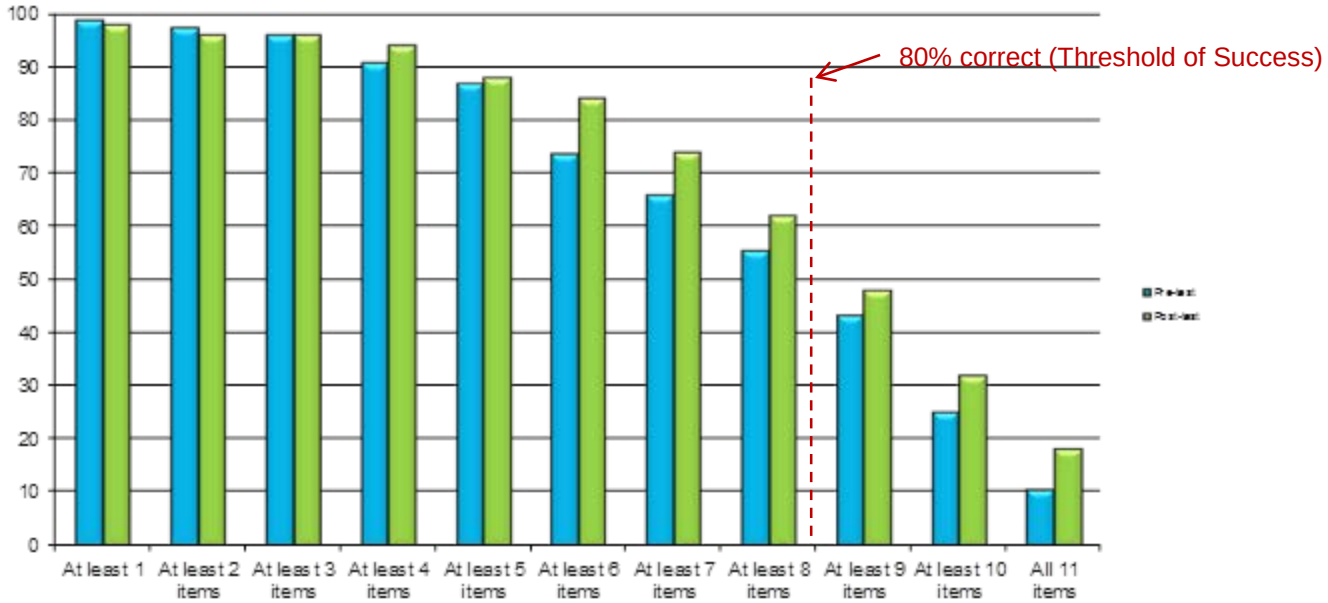


Figure 2 shows the cumulative percent of the Social Tolerance items reflecting non-stigmatizing responses. Prior to the intervention, 43% of students gave a non-stigmatizing response to at least 9 of the 11 questions (signifying an "A" grade). At post-test, this was 68% (reflecting a 5% improvement).

Figure 2. Cumulative Percent of Social Tolerance Scale Items Reflecting Non-stigmatizing Response



7 CONCLUSION

This report describes the results of a contact-based anti-stigma intervention provided to high school students. The results show that this program was successful in improving the proportion of students who got 80% of the answers correct, so received an “A” grade on the tests used to assess social stereotypes and social tolerance. The program achieved greater success in diminishing stereotyped attitudes (33.3% more students received an “A” grade at post-test than expressions of social tolerance (5% more students received an “A” grade at post-test).

The positive findings suggest that there are components of the program that work; although the program appears to be successful, particularly on the items of social stereotypes dealing with dangerousness and violence, a small number of students continued to hold stigmatizing beliefs despite their participation. In the future it might be beneficial for the speakers to deal more directly with areas related to social tolerance.

Program staff consider the speakers’ stories and their focus on recovery central to their success. They believe it is important that speakers are in a state of recovery and that they are properly trained.

Appendix A: Partnership Program Calgary

Percent Non-Stigmatizing Endorsement of Stereotyped Items

	Pre-test % (n=74)	Post-test % (n=48)
None	1.4% (1)	4.2% (2)
At least 1	98.6% (73)	95.8% (46)
At least 2 items	98.6% (73)	95.8% (46)
At least 3 items	93.2% (69)	95.8% (46)
At least 4 items	91.9% (68)	89.6% (43)
At least 5 items	82.4% (61)	89.6% (43)
At least 6 items	74.3% (55)	85.4% (41)
At least 7 items	60.8% (45)	85.4% (41)
At least 8 items	40.5% (30)	77.1% (37)
At least 9 items	25.7% (19)	66.7% (32)
At least 10 times	13.5% (10)	45.8% (22)
All 11 times	5.4% (4)	29.2% (14)

Percent Non-Stigmatizing of Endorsement of Social Tolerance Items

	Pre-test % (n=76)	Post-test % (n=50)
None	1.3% (1)	2.0% (1)
At least 1	98.7% (75)	98.0% (49)
At least 2 items	97.4% (74)	96.0% (48)
At least 3 items	96.1% (73)	96.0% (48)
At least 4 items	90.8% (69)	94.1% (47)
At least 5 items	86.9% (66)	88.0% (44)
At least 6 items	73.7% (56)	84.1% (42)
At least 7 items	65.8% (50)	74.0% (37)
At least 8 items	55.3% (42)	62.0% (31)
At least 9 items	43.2% (33)	48.0% (24)
At least 10 times	25.0% (19)	32.0% (16)
All 11 times	10.5% (8)	18.1% (9)